FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031971

Facility Name: Greenwood Care

Address: 1406 North Chicago Avenue (Number) Evanston (City) 60201 (Zip Code)

County: Cook

Telephone Number: (847) 328-7508 **Fax #** (847) 869-4878

HFS ID Number: 363487508001

Date of Initial License for Current Owners: 01/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Cary C. Buxbaum, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	145	Intermediate (ICF)	145	52,925	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,589	424		49,013	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,589	424		49,013	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.61%

D. How many bed-hold days during this year were paid by the Department?
1,676 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/1/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/1/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	151,423	16,919	25,445	193,787		193,787	(13,613)	180,174			1
2	Food Purchase		191,409		191,409	(15,202)	176,207	(16)	176,190			2
3	Housekeeping	148,413	31,320		179,733		179,733	(251)	179,482			3
4	Laundry		10,618	11,004	21,622		21,622		21,622			4
5	Heat and Other Utilities			131,613	131,613		131,613	1,777	133,390			5
6	Maintenance	46,193	44,037	123,645	213,875		213,875	(27,037)	186,838			6
7	Other (specify):*							5,463	5,463			7
8	**TOTAL General Services**	346,029	294,303	291,707	932,039	(15,202)	916,837	(33,678)	883,159			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	944,648	20,414	46,209	1,011,271		1,011,271	(14,693)	996,578			10
10a	Therapy			12,876	12,876		12,876	(5,094)	7,782			10a
11	Activities	123,311	10,644		133,955		133,955		133,955			11
12	Social Services	217,558			217,558		217,558		217,558			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							4,739	4,739			15
16	**TOTAL Health Care and Programs**	1,285,517	31,058	66,285	1,382,860		1,382,860	(15,048)	1,367,812			16
	C. General Administration											
17	Administrative	67,408		386,966	454,374		454,374	(325,918)	128,456			17
18	Directors Fees											18
19	Professional Services			116,237	116,237	(9,911)	106,326	(73,351)	32,975			19
20	Dues, Fees, Subscriptions & Promotions			31,830	31,830		31,830	(5,989)	25,841			20
21	Clerical & General Office Expenses	135,036	23,087	40,290	198,413		198,413	25,541	223,954			21
22	Employee Benefits & Payroll Taxes			296,758	296,758	15,202	311,960		311,960			22
23	Inservice Training & Education											23
24	Travel and Seminar			241	241		241	259	500			24
25	Other Admin. Staff Transportation			2,358	2,358		2,358	2,160	4,518			25
26	Insurance-Prop.Liab.Malpractice			111,914	111,914		111,914	981	112,895			26
27	Other (specify):*							24,439	24,439			27
28	**TOTAL General Administration**	202,444	23,087	986,594	1,212,125	5,291	1,217,416	(351,878)	865,538			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,833,990	348,448	1,344,586	3,527,024	(9,911)	3,517,113	(400,605)	3,116,508			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Greenwood Care #0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			54,060	54,060		54,060	128,153	182,213			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							302,341	302,341			32
33	Real Estate Taxes			108,582	108,582	9,911	118,493	4,926	123,419			33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)				34
35	Rent-Equipment & Vehicles			13,295	13,295		13,295	4,822	18,117			35
36	Other (specify):*							8,459	8,459			36
37	**TOTAL Ownership**			652,217	652,217	9,911	662,128	(27,579)	634,549			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,388	79,388		79,388		79,388			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,833,990	348,448	2,076,191	4,258,629		4,258,629	(428,183)	3,830,446			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	49,320	30		9
10	Interest and Other Investment Income	(23,415)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,295)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,397)	21		24
25	Fund Raising, Advertising and Promotional	(1,064)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(6,792)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(18,214)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,873)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(417,310)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (417,310)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (428,183)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Greenwood Care

ID# 0031971

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income - Jury Duty	$ (34)	10	1
2	Theft & Damage	(1,366)	21	2
3	Building Company - Professional Fees	(220)	19	3
4	COPE Dues	(1,761)	20	4
5	Non-Allowable Legal	(1,270)	19	5
6	Capitalized Repairs & Maintenance	(13,563)	6	6
7				7
8				8
9				9
10				10
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98				98
99				99
100				100
101	**Total**	(18,214)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(9,719)	(3,894)						(13,613)	1
2	Food Purchase	(16)											(16)	2
3	Housekeeping			498					(749)				(251)	3
4	Laundry													4
5	Heat and Other Utilities			691	1,086								1,777	5
6	Maintenance	(13,563)		822	(7,786)	125	(6,635)						(27,037)	6
7	Other (specify):*				740	1,039	3,684						5,463	7
8	**TOTAL General Services**	(13,579)		2,011	(5,960)	(8,555)	(6,845)		(749)				(33,678)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)			(12,946)				(1,713)				(14,693)	10
10a	Therapy						(5,094)						(5,094)	10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*				3,147		1,592						4,739	15
16	**TOTAL Health Care and Programs**	(34)			(9,799)		(3,502)		(1,713)				(15,048)	16
	C. General Administration													
17	Administrative			12,714	(43,606)	(279,426)	(15,600)						(325,918)	17
18	Directors Fees													18
19	Professional Services	(1,490)	220	(72,528)	703	11,492	(11,748)						(73,351)	19
20	Fees, Subscriptions & Promotions	(6,120)		54	77								(5,989)	20
21	Clerical & General Office Expenses	(15,555)	424	44,736	(4,393)	329							25,541	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			82	177								259	24
25	Other Admin. Staff Transportation			476	1,684								2,160	25
26	Insurance-Prop.Liab.Malpractice			273	375	333							981	26
27	Other (specify):*			8,174	2,941	13,324							24,439	27
28	**TOTAL General Administration**	(23,165)	644	(6,019)	(42,042)	(253,948)	(27,348)						(351,878)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(36,778)	644	(4,008)	(57,801)	(262,504)	(37,695)		(2,463)				(400,605)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Greenwood Care **#** 0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	49,320	75,776	1,210	1,847								128,153	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(23,415)	326,104	(224)	(124)								302,341	32
33	Real Estate Taxes			1,728	3,198								4,926	33
34	Rent-Facility & Grounds		(476,280)										(476,280)	34
35	Rent-Equipment & Vehicles			1,843	1,298	1,681							4,822	35
36	Other (specify):*		8,459										8,459	36
37	**TOTAL Ownership**	25,905	(65,941)	4,557	6,219	1,681							(27,579)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,873)	(65,297)	549	(51,582)	(260,822)	(37,695)		(2,463)				(428,183)	45

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Greenwood Care, LLC	Evanston	Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 476,280	Greenwood Care, LLC	100.00%	$	$ (476,280)	1
2	V	36	Amortization of Loan Fees		Greenwood Care, LLC		8,459	8,459	2
3	V	30	Depreciation		Greenwood Care, LLC		72,193	72,193	3
4	V	30	Depreciation - Sec. 754		Greenwood Care, LLC		3,583	3,583	4
5	V	32	Mortgage Interest		Greenwood Care, LLC		327,471	327,471	5
6	V	21	Office Expense		Greenwood Care, LLC		424	424	6
7	V	19	Professional Fees		Greenwood Care, LLC		220	220	7
8	V	32	Interest Income	1,367	Greenwood Care, LLC			(1,367)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 477,647			$ 412,350	$ * (65,297)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 498	$ 498	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	691	691	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	822	822	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	12,714	12,714	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,162	1,162	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	54	54	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	44,736	44,736	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	82	82	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	476	476	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	273	273	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	8,174	8,174	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,210	1,210	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	(224)	(224)	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,728	1,728	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	1,843	1,843	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	73,690	PREFERRED BOOKKEEPING	100.00%		(73,690)	32
33	V	19	COMPUTER	3,480	PREFERRED BOOKKEEPING	100.00%	3,480		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 77,170			$ 77,719	$ * 549	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,086	$ 1,086	15
16	V	6	REPAIRS AND MAINT.	13,056	S.I.R. MANAGEMENT, INC.	100.00%	5,270	(7,786)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	740	740	17
18	V	10	NURSING	28,716	S.I.R. MANAGEMENT, INC.	100.00%	15,770	(12,946)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,147	3,147	19
20	V	17	ADMINISTRATIVE	50,868	S.I.R. MANAGEMENT, INC.	100.00%	7,262	(43,606)	20
21	V	19	PROFESSIONAL FEES	0	S.I.R. MANAGEMENT, INC.	100.00%	703	703	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	77	77	22
23	V	21	CLERICAL & GENERAL	14,796	S.I.R. MANAGEMENT, INC.	100.00%	10,403	(4,393)	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	177	177	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	1,684	1,684	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	375	375	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,941	2,941	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	1,847	1,847	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	(124)	(124)	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,198	3,198	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,298	1,298	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 107,436			$ 55,854	$ * (51,582)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 14,796	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,077	$ (9,719)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,039	1,039	16
17	V	17	ADMIN./LEGAL SALARIES	320,373	S.I.R. MANAGEMENT, INC.	100.00%	36,832	(283,541)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	11,492	11,492	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	5,766	5,766	19
20	V								20
21	V	17	ADMIN. SALARY-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	2,529	2,529	21
22	V	6	REPAIRS & MAINT.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	125	125	22
23	V	21	CLERICAL & GEN.-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	257	257	23
24	V	26	AUTO INSURANCE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	228	228	24
25	V	27	EMP. BENEFITS-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	3,826	3,826	25
26	V	35	AUTO LEASE-B. BARRISH		S.I.R. MANAGEMENT, INC.	100.00%	853	853	26
27	V								27
28	V	17	ADMIN. SALARY-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	1,586	1,586	28
29	V	21	CLERICAL & GEN.-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	72	72	29
30	V	26	AUTO INSURANCE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	105	105	30
31	V	27	EMP. BENEFITS-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	3,732	3,732	31
32	V	35	AUTO LEASE-M. GIANNINI		S.I.R. MANAGEMENT, INC.	100.00%	828	828	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 335,169			$ 74,347	$ * (260,822)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	SPECIAL REHAB	12,876	S.I.R. MANAGEMENT, INC.	100.00%	7,782	$ (5,094)	15
16	V	15	EMP. BEN.-H. CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,592	1,592	16
17	V								17
18	V	6	REPAIRS AND MAINT.	18,936	S.I.R. MANAGEMENT, INC.	100.00%	12,301	(6,635)	18
19	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,517	2,517	19
20	V								20
21	V								21
22	V	1	DIETICIAN SALARIES	9,600	S.I.R. MANAGEMENT, INC.	100.00%	5,706	(3,894)	22
23	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,167	1,167	23
24	V								24
25	V	19	LEGAL FEES	11,748	S.I.R. MANAGEMENT, INC.	100.00%		(11,748)	25
26	V								26
27	V	17	FEES	15,600	S.I.R. MANAGEMENT, INC.	100.00%		(15,600)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,760			$ 31,065	$ * (37,695)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 73,421	$ 73,421	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	73,421	CCS EMPLOYEE BENEFIT GROUP	100.00%		(73,421)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 73,421			$ 73,421	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 0	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 0	$	15
16	V	02	FOOD	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		16
17	V	03	HOUSEKEEPING	7,558	XCEL MEDICAL SUPPLY, LLC	100.00%	6,808	(749)	17
18	V	04	LAUNDRY	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		18
19	V	06	REPAIRS & MAINTENANCE	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		19
20	V	10	NURSING	17,283	XCEL MEDICAL SUPPLY, LLC	100.00%	15,569	(1,713)	20
21	V	11	ACTIVITIES	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		22
23	V	21	CLERICAL & GENERAL OFFICE	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		23
24	V	22	EMPLOYEE BENEFITS	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		24
25	V	39	ANCILLARY	0	XCEL MEDICAL SUPPLY, LLC	100.00%	0		25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 24,840			$ 22,378	$ * (2,463)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Owner	Administrative	4.83%	see attached	3.16	7.90%	SIR salary	$ 2,529	17-7	1
2	Mike Giannini	Owner	Administrative	3.45%	see attached	4.74	11.85%	SIR salary	1,586	17-7	2
3	Louise Berghold	Owner	Administrative	3.45%	see attached	4.24	7.71%	SIR salary	14,678	17-7	3
4	Tom Winter	Owner	Administrative	4.14%	see attached	4.72	7.88%	Pref Bkp sal	12,714	17-7	4
5	Nenita Guzman	Relative	Dietary	0.00%	see attached	3.85	7.70%	SIR salary	5,077	1-7	5
6	Eric Rothner	Owner	Administrative	51.72%	see attached	0.56	1.21%	SIR salary	7,208	17-7	6
7	Adam Vales	Relative	Clerical	0.00%	see attached	0.49	1.23%	Salary alloc.	598	22-7	7
8	Kim Rudolph	Relative	Clerical	0.00%	see attached	0.36	1.03%	Salary alloc.	362	22-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 44,752		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	936,008	10	$ 6,321	$	73,690	$ 498	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	936,008	10	8,775		73,690	691	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	936,008	10	10,437		73,690	822	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	936,008	10	161,494	161,494	73,690	12,714	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	936,008	10	14,763		73,690	1,162	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	936,008	10	685		73,690	54	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	936,008	10	568,241	511,444	73,690	44,736	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	936,008	10	1,042		73,690	82	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	936,008	10	6,051		73,690	476	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	936,008	10	3,462		73,690	273	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	936,008	10	103,823		73,690	8,174	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	936,008	10	15,373		73,690	1,210	12
13	32	INTEREST	BOOK./ACCNT.INCOME	936,008	10	(2,849)		73,690	(224)	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	936,008	10	21,946		73,690	1,728	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	936,008	10	23,404		73,690	1,843	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						3,480	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 942,968	$ 672,937		$ 77,719	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	636,443	10	$ 14,105	$	49,013	$ 1,086	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	636,443	10	68,426	46,969	49,013	5,270	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	636,443	10	9,610		49,013	740	3
4	10	NURSING	PATIENT DAYS	636,443	10	204,773	204,773	49,013	15,770	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	636,443	10	40,863		49,013	3,147	5
6	17	ADMINISTRATIVE	PATIENT DAYS	636,443	10	94,293	94,293	49,013	7,262	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	636,443	10	9,125		49,013	703	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	636,443	10	999		49,013	77	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	636,443	10	135,090	96,485	49,013	10,403	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	636,443	10	2,293		49,013	177	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	636,443	10	21,870		49,013	1,684	11
12	26	INSURANCE	PATIENT DAYS	636,443	10	4,867		49,013	375	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	636,443	10	38,192		49,013	2,941	13
14	30	DEPRECIATION	PATIENT DAYS	636,443	10	23,979		49,013	1,847	14
15	32	INTEREST	PATIENT DAYS	636,443	10	(1,613)		49,013	(124)	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	636,443	10	41,530		49,013	3,198	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	636,443	10	16,852		49,013	1,298	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 725,254	$ 442,521		$ 55,854	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	636,443	10	$ 65,932	$ 65,932	49,013	$ 5,077	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	636,443	10	13,490		49,013	1,039	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	636,443	10	478,274	478,274	49,013	36,832	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	636,443	10	149,224		49,013	11,492	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	636,443	10	74,875		49,013	5,766	5
6										6
7	17	ADMIN. SALARY-B. BARRISH	AVG HRS WKD	20	4	16,008	16,008	3	2,529	7
8	6	REPAIRS & MAINT.-B. BARRIS	AVG HRS WKD	20	4	789		3	125	8
9	21	CLERICAL & GEN.-B. BARRISH	AVG HRS WKD	20	4	1,626		3	257	9
10	26	AUTO INSURANCE-B. BARRISH	AVG HRS WKD	20	4	1,444		3	228	10
11	27	EMP. BENEFITS-B. BARRISH	AVG HRS WKD	20	4	24,215		3	3,826	11
12	35	AUTO LEASE-B. BARRISH	AVG HRS WKD	20	4	5,400		3	853	12
13										13
14	17	ADMIN. SALARY-M. GIANNINI	AVG HRS WKD	30	4	10,035	10,035	5	1,586	14
15	21	CLERICAL & GEN.-M. GIANNI	AVG HRS WKD	30	4	457		5	72	15
16	26	AUTO INSURANCE-M. GIANNI	AVG HRS WKD	30	4	662		5	105	16
17	27	EMP. BENEFITS-M. GIANNINI	AVG HRS WKD	30	4	23,622		5	3,732	17
18	35	AUTO LEASE-M. GIANNINI	AVG HRS WKD	30	4	5,242		5	828	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 871,295	$ 570,249		$ 74,347	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	$ 65,110	$ 65,110	12,876	$ 7,782	1
2	15	EMP. BEN.-H. CARE & PROG.	SPECIAL REHAB INC.	107,736	7	13,322		12,876	1,592	2
3										3
4	6	REPAIRS AND MAINT.	MAINTENANCE INC.	144,648	10	93,966	93,966	18,936	12,301	4
5	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	144,648	10	19,226		18,936	2,517	5
6										6
7										7
8	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	74,533	74,533	9,600	5,706	8
9	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	15,250		9,600	1,167	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 281,405	$ 233,608		$ 31,065	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 73,421	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 73,421	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						6,808	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						15,569	6
7	11	ACTIVITIES	Direct Allocation							7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 22,378	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$35,561.55	3/1/95	$	$ 3,668,460	2/1/21	8.6900	$ 327,471	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Alloc. Preferred Bookkeeping		X								(224)	6
7	Alloc. SIR Management		X								(124)	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related				$35,561.55		$	$ 3,668,460			$ 327,123	9
	B. Non-Facility Related*											
10	Interest Income		X								(23,415)	10
11	Interest Income - Bldg Co.		X								(1,367)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (24,782)	14
15	TOTALS (line 9+line14)						$	$ 3,668,460			$ 302,341	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 127,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 121,308	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,492)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 120,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 9,911	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 123,419	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	129,713	8
	2001	119,340	9
	2002	121,326	10
	2003	124,779	11
	2004	116,382	12

2005 Accrual = 2004 Tax $116,382 x 1.03 = $120,000 (rounded)

Allocated from SIR Properties $3198

Allocated from Preferred Bookkeeping $1728

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-324-019-0000	Long Term Care Property	$ 116,382.36	$ 116,382.36
2.	See Attached	SIR Properties allocation	$ 86,511.09	$ 4,743.87
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 202,893.45	$ 121,126.23

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

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Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Greenwood Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,467 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility - Greenwood Care LLC		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	1,496	9
10	Various			1987	24,869		20	723	723	14,229	10
11	Various			1988	27,733		20	1,146	1,146	15,437	11
12	Various			1989	7,668		20	319	319	4,194	12
13	Various			1990	9,800		20	490	490	6,936	13
14	Various			1992	25,025		20	1,244	1,244	17,518	14
15	Various			1993	63,911		20	3,195	3,195	40,747	15
16	Various			1994	20,319		20	1,017	1,017	11,572	16
17	Various			1995	73,839		20	3,693	3,693	39,107	17
18	Various			1996	109,220		20	5,461	5,461	52,160	18
19	Various			1997	73,171		20	3,658	3,658	31,119	19
20	Various			1998	58,371		20	2,919	2,919	21,828	20
21	Various			1999	192,299		20	9,617	9,617	59,346	21
22	Various			2000	171,876		20	8,594	8,594	49,059	22
23	Various			2001	43,730		20	2,186	2,186	10,599	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,845,500	75,775		90,024	14,249	1,181,727	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		63,989	2,180		2,515	335	26,551	68
69	Financial Statement Depreciation			16,144			(16,144)		69
70	TOTAL (lines 4 thru 69)		$ 2,813,992	$ 94,099		$ 136,877	$ 42,778	$ 1,583,625	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,813,992	$ 94,099		$ 136,877	$ 42,778	$ 1,583,625	1
2	Railing	2002	1,335		20	134	134	523	2
3	Exit Signs	2002	11,525		20	1,153	1,153	4,418	3
4	Idph Improvement	2002	18,866		20	943	943	3,302	4
5	Idph Improvement	2002	8,556		20	428	428	1,497	5
6	Fire Door	2002	1,268		20	63	63	248	6
7	Sewer Work	2002	4,200		20	210	210	805	7
8	Sewer Work	2002	2,481		20	124	124	455	8
9	Boiler Work	2002	1,621		20	81	81	270	9
10	Painting	2002	317		20	32	32	119	10
11	Painting	2002	585		20	59	59	219	11
12	Painting	2002	1,432		20	143	143	561	12
13	Painting	2002	440		20	44	44	169	13
14	Radiator And Piping	2002	1,265		20	127	127	506	14
15	Room Repair	2002	1,025		20	103	103	333	15
16	Architect	2002	1,040		20	104	104	321	16
17	Frank Stowell Work	2002	31,650		20	1,583	1,583	4,879	17
18	Hood Exhaust	2003	3,264		20	326	326	816	18
19	Mixing Valve	2003	2,354		20	118	118	333	19
20	Fire Door	2003	3,905		20	195	195	439	20
21	Bathroom Work	2003	6,300		20	630	630	1,313	21
22	Bathroom Work	2003	2,250		20	225	225	469	22
23	Elevator Work	2003	4,400		20	220	220	477	23
24	Boiler Work	2003	10,800		20	540	540	1,170	24
25	Boiler Work	2003	4,132		20	207	207	465	25
26	Alarm Work	2003	1,043		20	52	52	109	26
27	Floor & Tile	2003	4,385		20	439	439	987	27
28	Drain Pipe	2003	640		20	64	64	149	28
29	Motor & Pump	2003	1,493		20	149	149	324	29
30	Drain Pipe	2003	1,765		20	177	177	397	30
31	Paint	2003	1,759		20	176	176	396	31
32	Tile	2003	1,491		20	149	149	385	32
33	Tile	2003	588		20	59	59	147	33
34	TOTAL (lines 1 thru 33)		$ 2,952,167	$ 94,099		$ 145,934	$ 51,835	$ 1,610,626	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,952,167	$ 94,099		$ 145,934	$ 51,835	$ 1,610,626	1
2	Architect Fees	2003	1,040		20	104	104	312	2
3	Tub Room Work	2003	7,500		20	375	375	781	3
4	New Windows	2004	2,100		20	105	105	210	4
5	Fire Door	2004	2,350		20	235	235	470	5
6	Tub Room Work	2004	10,500		20	525	525	1,006	6
7	Water Feeder	2004	1,376		20	138	138	252	7
8	Pump	2004	1,654		20	165	165	303	8
9	Hot Water Heater	2004	2,652		20	133	133	221	9
10	Hot Water Heater	2004	518		20	26	26	43	10
11	Painting	2004	10,392		20	520	520	823	11
12	Bathroom Tile Floor	2004	8,448		20	422	422	634	12
13	Window Treatment	2004	4,042		20	202	202	303	13
14	Handrails	2004	8,890		20	889	889	1,334	14
15	Boiler	2004	2,127		20	106	106	124	15
16	Nurse Call System	2004	1,252		20	63	63	125	16
17	Nurse Call & Phone System	2004	837		20	42	42	84	17
18	Radiator Piping	2004	1,110		20	56	56	106	18
19	Piping	2004	2,260		20	113	113	207	19
20	Window Treatments	2004	3,401		20	170	170	269	20
21	Cove Base	2004	4,997		20	250	250	396	21
22	Tiles	2004	700		20	35	35	55	22
23	Plumbing	2004	1,310		20	66	66	93	23
24	Tiles	2004	1,204		20	60	60	75	24
25	Piping	2004	500		20	25	25	31	25
26	Boiler Repair	2004	1,951		20	98	98	114	26
27	Plumbing	2004	1,440		20	72	72	90	27
28	Air Filtration System	2004	1,170		20	59	59	83	28
29	Hood Exhaust Fan	2004	1,033		20	52	52	69	29
30	Elevator Door Screen	2004	1,300		20	65	65	114	30
31	Elevator Door Edge	2004	1,300		20	65	65	114	31
32	Elevator Generator	2004	2,950		20	148	148	197	32
33	(4) Windows	2005	1,600		20	80	80	80	33
34	TOTAL (lines 1 thru 33)		$ 3,046,071	$ 94,099		$ 151,398	$ 57,299	$ 1,619,744	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,046,071	$ 94,099		$ 151,398	$ 57,299	$ 1,619,744	1
2	Ejector Pump	2005	2,575		20	107	107	107	2
3	Boiler Work	2005	1,951		20	98	98	98	3
4	Boiler Work	2005	2,037		20	102	102	102	4
5	Elevator Work	2005	4,800		20	220	220	220	5
6	Boiler Work	2005	1,322		20	55	55	55	6
7	Boiler Work	2005	2,495		20	104	104	104	7
8	Hot Water System	2005	1,253		20	52	52	52	8
9	Fire Door	2005	2,780		20	70	70	70	9
10	Fire Door	2005	1,150		20	38	38	38	10
11	Steal Door	2005	2,425		20	40	40	40	11
12	Elevator Generator	2005	6,850		20	29	29	29	12
13	Elevator Motor	2005	3,950		20	66	66	66	13
14	Sprinkler System	2005	3,110		20	6	6	6	14
15	Water Heater	2005	9,075		20	113	113	113	15
16	Repiping	2005	3,000		20	113	113	113	16
17	Alarm System	2005	1,655		20	55	55	55	17
18	Plumbing	2005	1,670		20	42	42	42	18
19	Plumbing	2005	3,650		20	76	76	76	19
20	Elevator Car Sill	2005	1,950		20	16	16	16	20
21	Sprinkler System Plumbing	2005	1,638		20	75	75	75	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
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9									9
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11									11
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,105,407	$ 94,099		$ 152,875	$ 58,776	$ 1,621,221	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1990		$ 1,845,500	$ 75,775		$ 90,024	$ 14,249	$ 1,181,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,845,500	$ 75,775		$ 90,024	$ 14,249	$ 1,181,727	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR Properties-Preferred Bookkeeping			1993	$ 11,117	$ 353	35	$ 318	$ (35)	$ 3,970	4
5	SIR Properties-SIR Management			1993	20,578	653	35	588	(65)	7,349	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Preferred Bookkeeping			1997	13,883	311	20	694	383	6,115	9
10	Allocated from Preferred Bookkeeping			1999	110		20	6	6	36	10
11	Allocated from Preferred Bookkeeping			2000	696		20	35	35	189	11
12											12
13	Allocated from SIR Properties-Preferred Bookkeeping			2002	44		20	2	2	8	13
14	Allocated from SIR Properties-Preferred Bookkeeping			1999	1,409	141	20	70	(71)	458	14
15	Allocated from SIR Properties-Preferred Bookkeeping			1998	673	67	20	34	(33)	252	15
16	Allocated from SIR Properties-Preferred Bookkeeping			1997	42	4	20	2	(2)	20	16
17	Allocated from SIR Properties-Preferred Bookkeeping			1994	106	3	20	5	2	61	17
18	Allocated from SIR Properties-Preferred Bookkeeping			1993	180	1	20	9	8	113	18
19											19
20	Allocated from SIR Management, Inc.			1993	8,838	246	20	438	192	5,697	20
21	Allocated from SIR Management, Inc.			1994	28		20			28	21
22	Allocated from SIR Management, Inc.			1995	202		20	10	10	105	22
23	Allocated from SIR Management, Inc.			1999	960		20	48	48	298	23
24	Allocated from SIR Management, Inc.			2000	580		20	29	29	165	24
25											25
26	Allocated from SIR Properties-SIR Management			2002	82		20	4	4	14	26
27	Allocated from SIR Properties-SIR Management			1999	2,607	261	20	130	(131)	847	27
28	Allocated from SIR Properties-SIR Management			1998	1,246	125	20	62	(63)	467	28
29	Allocated from SIR Properties-SIR Management			1997	78	8	20	4	(4)	37	29
30	Allocated from SIR Properties-SIR Management			1994	196	5	20	10	5	113	30
31	Allocated from SIR Properties-SIR Management			1993	334	2	20	17	15	209	31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 63,989	$ 2,180		$ 2,515	$ 335	$ 26,551	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 454,819	$ 28,415	$ 28,972	$ 557	10	$ 345,926	71
72	Current Year Purchases	4,528	10,380	367	(10,013)	10	367	72
73	Fully Depreciated Assets	70,248				10	70,248	73
74								74
75	TOTALS	$ 529,595	$ 38,795	$ 29,339	$ (9,456)		$ 416,541	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,787,557	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 132,894	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 182,214	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 49,320	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,037,762	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 8,454 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Faciltiy	2004 Chevy Van	$ 564.64	$ 6,776	17
18	Allocated from Preferred Bookkeeping			1,206	18
19	Allocated from SIR Management			1,681	19
20					20
21	TOTAL		$ 564.64	$ 9,663	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 13,431	$ 15,810	1
2	Cash-Patient Deposits	11,938	11,938	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	868,445	868,445	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,702	17,702	6
7	Other Prepaid Expenses	2,380	2,380	7
8	Accounts Receivable (owners or related parties)	315,000	315,000	8
9	Other(specify): See Attached Schedule	41,272	41,272	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,270,168	$ 1,272,547	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	608,790	608,790	15
16	Equipment, at Historical Cost	785,702	1,005,064	16
17	Accumulated Depreciation (book methods)	(849,172)	(2,142,690)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		101,513	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(83,533)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	20,574	45,002	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 565,894	$ 1,960,763	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,836,062	$ 3,233,310	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 93,056	$ 93,056	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,037	12,037	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	164,541	164,541	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,393	7,393	31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,000	120,000	32
33	Accrued Interest Payable		18,596	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	5,800	5,800	35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 402,827	$ 421,423	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,668,460	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,668,460	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 402,827	$ 4,089,883	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,433,235	$ (856,573)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,836,062	$ 3,233,310	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Greenwood Care **#** 0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,295,076	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,295,076	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	384,659	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(246,500)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 138,159	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,433,235	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,618,639	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,618,639	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,415	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 23,415	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,234	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,234	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,643,288	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	932,039	31
32	Health Care	1,382,860	32
33	General Administration	1,212,125	33
	B. Capital Expense		
34	Ownership	652,217	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,258,629	40
41	**Income before Income Taxes (line 30 minus line 40)****	384,659	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 384,659	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,681	2,086	$ 56,218	$ 26.95	1
2	Assistant Director of Nursing	1,860	1,991	46,962	23.59	2
3	Registered Nurses	66	66	1,436	21.76	3
4	Licensed Practical Nurses	12,637	13,117	310,008	23.63	4
5	CNAs & Orderlies	46,997	50,773	499,061	9.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,825	2,086	23,273	11.16	9
10	Activity Assistants	12,242	13,043	100,038	7.67	10
11	Social Service Workers	14,833	15,995	217,558	13.60	11
12	Dietician	2,001	2,086	28,977	13.89	12
13	Food Service Supervisor					13
14	Head Cook	5,233	5,742	44,353	7.72	14
15	Cook Helpers/Assistants	9,147	9,703	78,093	8.05	15
16	Dishwashers					16
17	Maintenance Workers	3,730	4,200	46,193	11.00	17
18	Housekeepers	16,854	17,748	148,413	8.36	18
19	Laundry					19
20	Administrator	1,861	2,086	67,408	32.31	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,858	15,058	135,036	8.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,385	2,687	30,963	11.52	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	147,210	158,467	$ 1,833,990 *	$ 11.57	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	23.5/monthly	$ 10,649	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	monthly	4,225	10-03	37
38	Nurse Consultant	monthly	28,716	10-03	38
39	Pharmacist Consultant	monthly	2,505	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Director of Food Services	monthly	14,796	01-03	47
48	Specialized Rehab Consultant	monthly	12,876	10A-03	48
49	TOTAL (lines 35 - 48)		$ 80,967		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	163	$ 4,368	10-03	50
51	Licensed Practical Nurses	189	6,395	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	352	$ 10,763		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Delvin Rychener	Administrator	0	$ 67,408
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,408

B. Administrative - Other

Description	Amount
SIR Management - Director of Admin. Services	$ 18,276
SIR Management - Ancillary Admin. Charges	32,592
SIR Management - Fees	15,600
See Supplemetal Schedule	320,498
TOTAL (agree to Schedule V, line 17, col. 3)	$ 386,966
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 12,565
Preferred Bookkeeping	Accounting	28,450
Preferred Bookkeeping	Bookkeeping	45,240
Preferred Bookkeeping	Computer Support	3,480
SIR Management	Dir of Regulatory Services	11,748
Personnel Planners	Unemployment Tax Consult	1,897
Rieff Schramm & Kanter	Legal - RE Tax Appeal	9,144
LTC Solutions	Computer	1,320
ICS	Computer	180
Scott Forest	Legal - Collections (adj p. 5)	70
Adjusted out Page 5	Legal	1,200
Illinois Assoc of Health Care	Legal	943
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 116,237

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,124
Unemployment Compensation Insurance	39,180
FICA Taxes	137,069
Employee Health Insurance	93,290
Employee Meals	15,202
Illinois Municipal Retirement Fund (IMRF)*	
401K Matching Contributions	7,296
Other Employee Benefits	1,799
TOTAL (agree to Schedule V, line 22, col.8)	$ 311,960

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,925
Health Care Worker Background Check	420
(Indicate # of checks performed 42)	
Advertising & Promotion	1,064
Dues & Subscriptions	7,590
Licenses & Permits	12,775
Allocated from Preferred Bookkeeping	54
Allocated from SIR Management	77
Less: Public Relations Expense	( )
Non-allowable advertising	(1,064)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,841

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	241
Allocated from Preferred Bookkeeping	82
Allocated from SIR Management	177
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 500

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Greenwood Care # 0031971 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Greenwood Care # 0031971 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long Term Care $7439**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,036** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,388**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,202** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.